Employee Benefits Report

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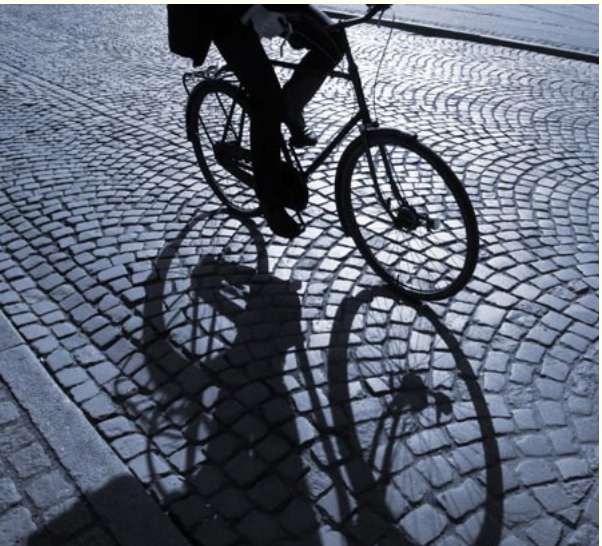
Try Transportation Benefits for Greener, Leaner Employees

Providing your employees with commuter benefits can enhance your reputation as a "green" employer, and may even improve employee wellness by encouraging them to get out of their cars.



What Are Qualified Transportation Benefits?

Certain transportation benefits qualify for tax-preferred treatment. They include:

- A ride in a commuter highway vehicle between the employee's home and workplace.
- A transit pass.
- Qualified parking.
- Qualified bicycle commuting reimbursement.

Employees can exclude the value of these benefits from their gross income for income tax purposes; the employer can exclude them from employees' wages for payroll tax purposes. For 2012, employees can exclude a maximum of:

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This Just In…

How do your sick leave policies compare? The Bureau of Labor Statistics recently reported that 73 percent of full-time private industry workers in the U.S. had paid sick leave plans in 2009. The following are some of the most common types of plans:

1. **Fixed number of days per year.** For example, a worker may get 12 days of sick leave at the start of the year to be used at any time during the year. Alternatively, the employer may allow the worker to accumulate days based on time worked.
2. **A plan that provides sick leave on an "as-needed" basis.** These plans are less formal and have no pre-determined number of paid sick leave days.

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- $125 per month for public transit benefits (includes mass transit and vehicles seating 14 or more passengers operated by a person in the business of transporting persons for pay or hire.)
- $240 per month in qualified parking benefits. This includes parking on or near your premises or parking at the location where your employees commute to work using mass transit, commuter highway vehicles or carpools.
- $365 per month for both public transportation and qualified parking.

In addition, employers can reimburse employees up to $20 per month for any "reasonable expenses" the employee incurs for bicycle commuting. These expenses can include the purchase, repair, improvements and storage of a bicycle incurred during any month in which the employee regularly uses the bicycle for a substantial portion of travel between his/her residence and place of employment. He/she cannot receive employer-provided transportation in a commuter highway vehicle (such as a vanpool), transit pass or qualified parking benefits during that month.

Administering Commuter Benefits

Employers can structure a commuter benefit program in many ways.

1. Direct benefits – An employer can provide qualified transportation benefits directly to employees, by either providing free parking, rides in company-provided van pools or as vouchers or passes given directly to employees.
2. Reimbursement plan – Employees can set aside pre-tax dollars to use toward commuting expenses. To receive reimbursement, employers must present documentation of qualified work-related commuting expenses. Administering a reimbursement plan might cost an employer $4 to $5 per employee per month; however, the employer pays no FICA on money employees put into the plan.

The IRS allows cash reimbursements for transit passes only if a voucher or a similar item that the employee can exchange only for a transit pass is not readily available for direct distribution by you to your employee. A voucher is readily available for direct distribution only if an employee can obtain it from a voucher provider that does not impose fare media charges or other restrictions that effectively prevent the employer from obtaining vouchers.

3. **A consolidated leave plan. In these plans, multiple forms of leave are combined into one plan. For example, workers might receive four weeks of leave for vacation and illness or disability, to use as they choose.**

Among full-time workers with paid sick leave plans, 68 percent had a fixed number of days of paid sick leave each year; 10 percent received paid sick leave on an as-needed basis; while the remaining 22 percent received paid sick leave through a consolidated leave plan.

Generally, you can exclude qualified transportation fringe benefits from an employee's wages even if you provide them in place of pay. However, qualified bicycle commuting reimbursements cannot be excluded if the reimbursements are provided in place of pay. If the value of a benefit for any month is more than its limit, you must include the amount over the limit in the employee's wages, minus any amount the employee paid for the benefit.

For transportation benefits, an employer should treat the following individuals as employees.

- A current employee.
- A leased employee who has provided services to you on a substantially full-time basis for at least a year, if the services are performed under your primary direction or control.

Self-employed individuals and 2 percent shareholders of S corporations do not qualify as employees for tax-favored treatment of transportation benefits. A 2 percent shareholder is someone who directly or indirectly owns (at any time during the year) more than 2 percent of the corporation's stock or stock with more than 2 percent of the voting power. Treat these individuals as you would a partner in a partnership for fringe benefit purposes, but do not treat the benefit as a reduction in distributions.

For more information on setting up or administering a commuter benefits program, please contact us. ■

How to Start a Wellness Program

June is National Employee Wellness Month, which "…showcases how supportive social communities, such as the workplace, can help to improve employee health and productivity and lower healthcare costs, and how leveraging an individual's social connections helps create and sustain a workplace culture of health." It's also a good time to start a wellness program. If your organization doesn't already have one, the following suggestions can help you start one.

Step 1: Get Management Support

Wellness programs aim to prevent or control chronic conditions and reduce their associated treatment costs. The National Business Group on Health estimates that preventive services return $300 for every $100 spent. Department of Health and Human Services Secretary Kathleen Sebelius said that chronic diseases cause seven out of 10 deaths and account for about three-fourths of the nation's medical expenditures. To make your case in favor of wellness, take a look at the specific costs and challenges your organization faces.

Step 2: Assign Responsibility

In addition to having a manager to direct your program, you might want to form a wellness committee.

A committee that represents a broad range of functional areas and job levels will promote diversity of viewpoints and wider program acceptance. It can help develop goals and objectives, assess employee needs and preferences and evaluate current programs.

Individuals who already deal with some aspect of employee health or well-being, such as human resources, employee benefits, safety, employee cafeteria and union representatives, make good candidates, as well as people responsible for environmental and policy changes (e.g., facilities and operations, legal department). Consider including at-large employee representation, including those with disabilities.

Step 3: Identify Your Wellness Focus

Your wellness program will yield the best payoff if it focuses on the most costly and easily preventable conditions. Obesity is emerging as one of the leading healthcare crises of our time. With strong links to preventable chronic diseases, such as Type 2 diabetes, heart disease and stroke, as well as to certain cancers, it affects nearly one-third of the adult population in the U.S. In fact, obesity recently overtook smoking as the leading cause of preventable healthcare costs in the U.S.

Just how costly is obesity? The Mayo Clinic found that annual health costs for obese individuals averaged $1,850 more than for normal-weight people. For the morbidly obese, or those with a body mass index (BMI) of 40 and higher, excess costs rose to $5,500 annually.

Step 4: Identify Resources and Programs

Let's say you've agreed to focus wellness efforts on overweight/obesity. In addition to taking advantage of any in-house expertise on exercise, nutrition and training, you can seek information and assistance from the following individuals and organizations: your insurance agent, your insurer, association/trade groups, government agencies and wellness program vendors. What types of programs work, in their experience? How much do they cost? What obstacles or problems have they encountered?

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You can also find free wellness information on the Internet. A couple of sources employers might find valuable include the National Business Group on Health (www.businessgrouphealth.org), the Wellness Council of America (www.welcoa.org) and the U.S. Chamber of Commerce (see their "wellness toolkit.").

Step 5: Integrate Wellness with Other Programs

Just as wellness involves an individual's whole body, a company wellness program should involve the entire company. Your wellness program should coordinate with:

- Benefits – Does your wellness program take advantage of benefits covered by your group health plan?
- Workers' compensation/safety – Could the program address any weight-related safety problems or return-to-work concerns?
- Human resources – Does the program comply with nondiscrimination laws and company policies? Does the HR department promote wellness in company publications, recruiting materials, etc.?

Step 6: Use Peer Pressure

Studies have proved that when individuals associate with others who eat well and exercise regularly, they are more likely to do so as well. Since full-time working adults spend more of their waking time at the workplace than anywhere else, it makes sense to make good health part of your corporate culture.

Step 7: Address Emotional Barriers

Depression and other emotional problems can lead to overeating and abuse of alcohol or drugs. Providing employees with access to mental health services, either through your insurance plan or an employee assistance program, can help address these problems and other barriers to change.

Step 8: Offer Rewards

Offering a meaningful reward can boost interest and participation. Rewards can be directly related to wellness—such as a reduction in health insurance premiums—or not. Just make sure incentives are available to all employees. If certain employees cannot qualify, such as disabled individuals, have alternative rewards available.

Step 9: Make It Fun

Change is hard, and maintaining interest even harder. Make your program fun by adding elements of fun and healthy competition, and watch participation rates soar!

Step 10: Evaluate

In your planning process, you should have broken your program's overall goals into an achievable set of definable, short-term objectives. How well are you achieving those objectives? Adjust your program—or your objectives—as necessary.

For more information on starting a wellness program, please contact us. ■

More Employers Considering Self-Insured Health Plans

Traditionally the domain of big business, self-insured health plans are gaining ground among mid-sized and smaller employers. What are the advantages and disadvantages of self-funding?

In a self-insured, or "self-funded," group health plan, the employer assumes the financial risk for providing health care benefits to its employees. Self-insured employers pay for each claim, out of pocket, as it is incurred. This differs from a fully insured plan, in which the employer pays a fixed premium to an insurance carrier, which pays covered claims on the employer's behalf.

Self-Insurance Plans Are Flexible

Typically, a self-insured employer will set up a special trust fund to earmark money to pay incurred claims. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. This special coverage protects self-insured employers' cash flow by paying when the health plan experiences catastrophic or unusual losses.

Some self-insured employers contract with insurance carriers or third-party admin-

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istrators for claims processing and other administrative services; other self-insured plans are self-administered.

Benefits of Self-Insuring

Tailored coverage. Self-insured plans give employers greater flexibility in plan design than fully insured plans. You can customize the plan to meet the specific health care needs of your workforce, as opposed to purchasing a "one-size-fits-all" insurance policy.

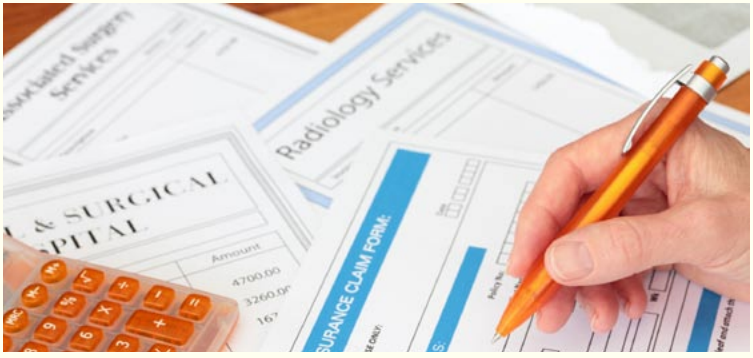
Exemption from Affordable Care Act provisions. Self-insured plans are exempt from the small-group rating regulations, risk adjustment policies, and essential health benefits provisions of the ACA. According to a RAND report, "These regulations may tend to increase prices for lower-risk groups (i.e., groups that tend to have lower claims costs), while reducing premiums for higher-risk groups. As a result, lower-risk groups may opt to avoid the regulations by self-insuring."

Exemption from state health insurance regulations. Self-insured health plans fall under federal law (ERISA) regulations and are therefore exempt from state regulations. Many states require all health insurance policies sold within their borders to cover certain treatments/procedures, such as mammograms, "well baby" exams, etc. These state-mandated benefits drive up the cost of coverage.

Removal from high-cost pools. In the majority of states, insurers medically underwrite small employer groups (between 50-100 lives), meaning that the insurer will look at your group's claims experience to determine rates. In the remaining states, however, they rate small group policies on a modified community basis. This means small groups are pooled with similar groups, and coverage is priced on a community basis rather than per group. Relatively young, healthy groups end up subsidizing coverage for older, less-healthy groups. If this situation sounds familiar, your organization might benefit from self-funding.

Exemption from health insurance premium taxes. A self-funded plan is not subject to health insurance premium taxes in most states. These taxes generally equal 2-3 percent of the premium amount.

Greater transparency. Under a fully insured plan, the insurer handles claims so the employer doesn't necessarily know what its claim history is. A self-insured plan doesn't insulate employers from their



claims data, which allows you to adjust your plan to fit employees' needs and work to improve chronic health problems.

Options for Smaller Groups

Smaller employers can opt to partially self-fund their health plans. For example, under a partially self-funded plan, the employer might pay claims for doctor visits and prescription drugs for covered individuals. It would then contract with an insurance carrier to cover hospitalizations and major medical claims.

A health reimbursement arrangement (HRA) paired with a high-deductible plan gives smaller employers some of the benefits of a self-funded arrangement while minimizing the risks. Employers can offer an HRA in conjunction with other employer-provided health benefits. Employers have complete flexibility to offer various combinations of benefits in designing their plan, with no limit on the amount of money they can contribute to employee accounts. Employers alone fund HRAs; employer contributions do not count toward employees' taxable income.

Under IRS regulations, distributions from an HRA must reimburse only "qualified medical expenses" incurred on or after the date of enrollment. Employees and covered dependents must provide proof of claim for reimbursement; however, you can also use debit cards, credit cards and stored value cards to ease administration.

Third-party administrators can handle HRA setup and administration. For more information on this and other self-funding options, please contact us.

Why Self-Insured Employers Need Stop Loss Insurance

No discussion of self-insured health plans would be complete without an examination of stop loss reinsurance. Self-insured employers can buy stop loss reinsurance to protect themselves when claim costs exceed their expectations. This form of reinsurance for self-insured employers limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).

Two types of stop loss reinsurance exist: **individual stop loss**, or **specific deductible stop loss**, protects you from large claims from an individual insured or dependent. If an individual insured under your health plan has claims that reach a specified dollar amount, the reinsurance kicks in. The reinsurer will then pay claims for that individual for the rest of the plan year.

Aggregate stop loss coverage limits the employers' total liability to a specified dollar amount during a specified period, usually either a plan year or month. If your claims reach the "attachment point," the reinsurer will pay claims over that amount.

How much stop loss insurance you'll need depends on a variety of factors. Your company's cash reserves and cash flow play a role, but you'll also need to determine how much risk you're comfortable assuming. Although self-insured plans do not fall under state regulation, stop loss coverage does. In 16 states, regulators prohibit insurers from selling stop-loss policies with an "attachment point" below a specified limit, which ranges from $5,000 to $25,000, reports RAND. Your organization would have to pay all claim amounts below the attachment point.

Knowing your group's claims history can help, as well as knowing the types and costs of claims groups similar to yours experience. An experienced health benefit professional can help you determine whether a self-insured plan could save you money. For more information, please contact us.

Stop loss reinsurance protects self-insured employers' cash flow. To discuss stop loss or self-insurance with us, please call. ■

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